PREPARING PEOPLE FOR CHANGE:
KNOWLEDGE AND CHOICE
The Third National Conference Addressing Homelessness for People with Mental Illnesses and/or Substance Use Disorders
October 26-28, 2005, Washington, DC

Exemplary Programs:
Background Information
(Programs listed alphabetically by State)

Homeward Bound
Anchorage, Alaska

Inception: 1997

Treatment Population: Chronically homeless individual adults, many of whom have co-occurring disorders (80% Alaska Native)

Website: www.ruralcap.com


Mr. Curie presents award to Homeward Bound

Homeward Bound applies a motivational enhancement and self-directed change model to treatment services. Homeward Bound believes in a holistic approach; treating the entire person and addressing co-existing conditions *concurrently*, not *separately*. Working from a modified version of the theoretical stages of change model, the program provides and/or coordinates a full array of services including primary care, mental health, money management, employment, housing, and legal and entitlement assistance. Through active collaboration with local consumers and agencies, Homeward Bound seeks to encourage self-actualization and self-efficacy on the part of clients, instilling self-esteem and a new opportunity for independent living.

Outcomes:
- 59% reduction in Community Service Patrol Transfer Station stays of Homeward Bound participants, creating a significant cost savings for the community
- 88% of clients work full- or part-time
- 85% of graduates have maintained stable housing from six (6) months to six (6) years

- Contact maintained with 208 of the 209 individuals who have participated in the program, highlighting the importance of relationship-building in the Homeward Bound treatment model

Project HOPE
Concord, CA

Inception: 2001

Treatment Population: Homeless individual adults suffering from co-occurring substance abuse and mental health disorders

Website: www.projecthope.org


Mr. Curie presents award to Project Hope

The primary goal of Project HOPE is to raise the quality of life for people of Contra Costa County who are living in places not intended for human habitation. Project HOPE provides support to these individuals in an effort to help them define and attain their goals so that they can transition to a safe and healthy life. The ten key components of Project HOPE's integrated treatment approach include multidisciplinary assertive outreach & intensive case management; adherence and implementation of "No Wrong Door;" simultaneous treatment of substance abuse and mental health issues; stages of change/motivational interventions; counseling/cognitive-behavioral therapy; social support interventions; comprehensive wraparound services; consumer involvement; cultural competence; and a longitudinal view of recovery.

Outcomes:
- Approximately 1,500 contacts with the homeless population in Contra Costa County since November of 2003, with more than 800 people placed in shelter or detoxification and 80 individuals provided permanent housing
- More than 60% of contacts receive integrated mental health and substance abuse assessments
- More than 150 homeless men and women able to obtain California Identification cards
- More than 120 men and women have entered long-term substance abuse treatment programs
- Provision of food, clothing, health assessment, transportation, and sleeping bags and tents to hundreds of homeless men and women

El Hogar River City Community Homeless Program (RCCHP) and **Turning Point Community Program's Homeless Intervention Program (HIP)**
Sacramento, CA

Inception: N/A

Treatment Population: Homeless individual adults with co-occurring substance abuse and mental health disorders, including serious mental illness


Mr. Curie presents award to RCCHP and HIP

Websites:
www.elhogarinc.org/rcchp.htm
www.tpcp.org/Programs/HIP.htm

El Hogar River City Community Homeless Program (RCCHP) and Turning Point Community Program's Homeless Intervention Program (HIP) both provide integrated and comprehensive homeless, substance abuse treatment, and mental health services through the work of a multi-disciplinary staff with 24/7 crisis response and programming. Services are recovery- and rehabilitation-focused and include housing assistance, employment training, and access to medical care. Each program is firmly grounded in evidence-based practices tailored to the individual needs of clients. RCCHP and HIP also enhance their services through community collaboration, continual self-evaluation, and a focus on cultural competency.

Outcomes (among clients enrolled in either program for four years or more):
- Homeless days decreased by 99%
- Incarcerations decreased by 68%
- Hospitalizations decreased by nearly 78%

Fellowship House's Community Housing Program
South Miami, FL

Inception: 1973
Treatment Population: Homeless adults with mental health and/or substance use disorders

Website: www.fellowshiphouse.org

Fellowship House Community Housing Program accepts award

Fellowship House's success in transitioning homeless adults with severe and persistent psychiatric disabilities and/or co-occurring disorders to normalized, community living can be attributed to the vast array of services rendered. The ideals of the Clubhouse model, which emphasizes consumer input and involvement as integral to everyday program operation, is combined with a psycho-educational approach to maximize service individualization. Fellowship House provides a comprehensive continuum of services in each of its five facilities, with a focus on supportive employment and an ongoing willingness to adapt to changing populations served and new research, anchored by a cooperative and consultative relationship with the Miami-Dade County Homeless Trust.

Outcomes:

- Over 99% of program participants able to avoid psychiatric hospital recidivism
- Over 80% of participants demonstrate improved level of functioning, as evidenced by increased Global Assessment of Functioning (GAF) scores
- 98% of clients able to maintain permanent supportive housing long-term
- Community Housing clients able to maintain a GAF score of 48 or more, on average

Helping Other People Through Empowerment, Inc.
Baltimore, MD

Inception: 1998

Treatment Population: Consumer-run drop-in center targeting individuals and families who are homeless with a mental illness, homeless and have substance use disorders, and homeless and have co-occurring disorders

Website: www.jhu.edu/redcross

Mr. Curie presents award to Helping Other People Through Empowerment

Helping Other People Through Empowerment, Inc.'s (HOPTE's) mission is to assist adults with mental illness in Baltimore County with becoming empowered by increasing awareness of the resources available using peer support in a comfortable and supportive environment. The key components of HOPTE's treatment approach include self-help/peer support, psycho-education for clients and families, integrated treatment for persons with co-occurring disorders (including professionally facilitated Double Trouble groups), and collaborative outreach with the city's mental health, homeless, crisis response, and mobile treatment providers. The program also offers fully integrated referral to substance abuse, mental health, and primary care, entitlements and veteran's assistance, and criminal justice diversion.

Outcomes (annual approximations):

- 57 consumers experience residential stability
- 125 secure shelter and transitional housing
- 26 securing permanent housing
- 137 secure outreach and/or case management services
- 60 now receive mainstream benefits

Maryland SSI Outreach Project
Baltimore, MD

Inception: 1993

Treatment Population: Individuals who are homeless, who have serious and persistent mental illness and/or co-occurring disorders (including mental illness and substance use, HIV, a history of trauma, organic mental disorders, and other ongoing physical health problems)

Mr. Curie presents award to Maryland SSI Outreach Project

Website:
http://medschool.umaryland.edu/Psychiatry

The Maryland SSI Outreach Project is committed to ending homelessness through the development and sharing of a nationally replicated model that combines outreach to individuals who are homeless with serious mental illness and assistance with increased access to benefits—including Supplemental Security Income (SSI)—available through the Social Security Administration (SSA). The program emphasizes four key promising practices:

1. The initial SSI Application Process: Maryland SSI works with each client to create a comprehensive personal, treatment, and work history. From this information, they create a *medical summary report* which links the applicant's impairment and his or her employment history, thus overcoming a factor that often results in unfavorable determinations.
2. Outreach: Maryland SSI staff receive training to complete applications on an outreach basis, making it possible to work with clients where they are most comfortable.
3. Presumptive Disability Determinations: These allow applicants to receive benefits while ongoing benefits applications are being processed.
4. Maintaining Benefits: Maryland SSI coordinates representative payees for benefit recipients, allowing those recipients to more effectively manage their money.

Outcomes:

- Final determination data is available for 608 SSI applicants over seven years (1993-2001). Overall, 65% of applicants were approved for ongoing SSI benefits, almost twice the national average (37%) as reported by the SSA.
- The project was named a Best Practice in 2001 by the National Alliance to End Homelessness.
- With funding from SAMHSA, a training curriculum titled *Stepping Stones to Recovery* has been developed based on the approached used by the project.

- The SAMHSA SSI Transformation Initiative, based in part on the project's outreach model, will develop additional training and technical assistance for states and communities in an effort to create enduring protocols and local training capacity to more effectively assist homeless applicants for SSI.

Worcester Homeless Families Program (WHFP)
Worcester, MA

Inception: 1988

Treatment Population: Families whose heads of household and their dependent children reside in Worcester family shelters, in doubled-up housing, or otherwise precarious housing situations

Website: www.fhcw.org/homeless.htm

Mr. Curie presents award to Worcester Homeless Families Program

The WHFP is an integrated mental health/primary care treatment program for homeless families and their children that continues once the family locates permanent housing to assure the family is stabilized. A multi-disciplinary team provides a core set of wrapping services which include primary health care delivered by a family provider, family advocacy, and clinical/psychological sessions. Services are provided on-site and through outreach in shelters, client homes, and schools. Development and continued refinement of the intervention approach is guided by:

- Extensive data collected during the Worcester Family Research Project, an NIMH-funded longitudinal investigation of 220 homeless and 216 housed poor families conducted between 1991 and 1997
- A recently completed evaluation of the WHFP intervention funded by SAMHSA
- Research from several University of Massachusetts Medical School (UMMS) research projects on the experiences and needs of, and interventions for, parents with mental illness and their families
- Findings from other studies on vulnerable families
- Extensive consumer input and linking with mainstream services

Outcomes:

- WHFP families typically achieve outcomes of increased participation in services, movement to stable housing, decreased adult substance use and psychological distress, improved overall health, and improved parent and child functioning

- Over 90% of children ages 0 to 4 enrolled in school readiness attended class on a regular basis, and over 90% of children ages 5 to 6 identified as needing special education services received individual education plans within one year
- 95% of children ages 0 to 6 received scheduled preventive well-child health visits
- 91% of adults had preventive health needs met
- 97% of WHFP mothers conducted play/educational activities at least two times a week with each child

Project Outreach Team (PORT)
Ann Arbor, MI

Inception: 2000

Treatment Population: Persons who are homeless and mentally ill in Washtenaw County (southeastern Michigan)

Website: www.a2port.org


Mr. Curie presents award to Project Outreach Team

The goal of the Project Outreach Team (PORT) is to support the full independence, psychiatric stability, and quality of life for individuals within the community. PORT staff work as a team to provide continual, direct, holistic support, helping with life's most basic needs: housing, food, and clothing. PORT provides a vast array of services through outreach and engagement, including assertive street outreach, co-occurring outreach, intensive case management, psychiatric services, trauma-informed group services for women, nursing services, Dual Diagnosis programming, a Medication Only Clinic, jail diversion, consultation, and supported employment and export services. PORT provides multi-language materials and translation services for culturally diverse clients. In addition, diversity training is routinely provided of all staff.

Outcomes:
- In 2000, the University of Michigan received a Flinn Family Foundation grant to design, implement, and research the effectiveness of PORT.
- In 2003, PORT became first co-occurring outreach team in Michigan.
- Collaboration with community legal resources has resulted in 100% of all cases being approved by the Social Security Administration (SSA) on first application or appeal.

350 Lafayette Transitional Living Community (The 350 TLC)
Center for Urban Community Services, Inc. (CUCS)
New York, NY

Inception: 1989

Treatment Population: Single, homeless women in New York City living with serious or persistent mental illness

Website: www.cucs.org


Mr. Curie presents award to 350 TLC

The primary goal of treatment at the 350 TLC is placement for each client into permanent housing that fits their needs, preferences, and abilities. The 350 TLC services include on-site psychiatric and medical treatment, housing-focused case management services, entitlements assistance, housing placement, and post-placement follow up services. As an extension of its goal-directed support service orientation, CUCS has implemented Wellness Self Management (WSM) and *Seeking Safety*:

- WSM is a professionally guided set of specific, mutually reinforcing practices designed to help clients set and make progress toward personal recovery goals, know more about psychiatric illnesses and their treatment, learn to use medication effectively, develop relapse prevention plans, and develop strategies for coping with persistent symptoms and other problems.
- *Seeking Safety* at the 350 TLC consists of two weekly groups facilitated by a social worker with expertise in using the curriculum, which was developed by Dr. Lisa Najavits. These psycho-educational groups help clients understand the dynamics of domestic violence, its effects, and its treatment. Participants learn to recognize and resolve unsafe relationships and build safety-coping skills. As a supplement to *Seeking Safety*, the social worker offers a weekly "Women's Issues" group to further assist participants in identifying and resolving the lingering effects of their domestic violence experiences. Having achieved positive participant outcomes, CUCS will now make the customized *Seeking Safety* curriculum available agency wide.

Outcomes:
The 350 TLC has exceeded its placement target each year with an average annual placement of over 65 clients for the past eleven years. According to the New York City Department of Homeless Services Annual Placement Report, this is a higher per bed placement rate than any shelter in its category in New York City. On average, it has achieved 237% of its placement target for each of the 11 years of its contract.

Albert and Mildred Dreitzer Women and Children's Treatment Center and **Families United Supportive Housing (FUSH)**
Programs of Palladia, Inc.
New York, NY

Inception: 1992

Treatment Population: Families who are homeless and have co-occurring disorders

Website: www.palladiainc.org


Mr. Curie presents award to FUSH

The Dreitzer Center facilitates transition to independent living for mothers and their children. The Center is an innovative 12-15 residential substance abuse treatment program, licensed by the New York State Office of Alcohol and Substance Abuse and one of ten mother/child residential treatment programs in the state. FUSH is closely connected with the Center; its staff is physically located at the Center, and a majority of its clients are referred to the program after receiving services at the Center. FUSH is the only supportive family housing program of its kind in New York City that offers both apartments with rental subsidies and intensive case management for women with underlying trauma and mental illness and their children.

Outcomes:
More than 75% of the residents who are admitted and stay in these programs for more than 90 days each year attain their goals in the following areas:

- Discontinuation of use of primary substance
- Completion of 12 weeks of mental health/substance abuse psycho-education group
- Participation in at least 36 weeks of recovery skills groups
- Participation in at least 24 weeks of *Helping Women Recover* and *Seeking Safety*
- Participation in at least 36 weeks of parenting skills curriculum
- Completion of vocational & educational skills assessment
- Participation in at least 36 weeks of vocational/educational rehabilitation groups
- Ongoing treatment of health conditions identified at intake

Homeless Outreach Program at Southeast, Inc.
Mobile Psychiatric Unit and Project Liaison
Columbus, OH

Inception: N/A

Treatment Population: Adults in who are homeless and have a severe mental illness

Website:
southeastinccom.gripserver.com

Mr. Curie presents award to Homeless Outreach Program

The Homeless Outreach Program is comprised of the Mobile Psychiatric Van and Project Liaison. The Mobile Psychiatric Unit utilizes a medically-equipped van to take outreach, engagement, and treatment services to homeless people in emergency shelters and at large. The Unit employs a psychiatrist, nurse, case managers, and a substance abuse specialist, and provides case finding, engagement, treatment, and services for linkage to health care, veteran's and entitlements assistance, Supplemental Security Income (SSI), and programs such as Temporary Assistance for Needy Families (TANF). Project Liaison provides outreach, case finding, and case management services to persons with severe and persistent mental illness who are homeless and not yet ready to be fully linked with a behavioral healthcare provider. The team's case management services are low-demand and client-centered. This method is based on the concept of "meeting the client where they're at"—literally and figuratively.

Outcomes:

- In the first half of the current fiscal year, the Homeless Outreach Program reached out to 247 people who were homeless and mentally ill. Of these, 122 agreed to receive services from the team.
- With carry-overs from previous years, the team served 234 individuals with direct services (not just outreach alone). 67 individuals (29%) were housed and 41 (18%) were linked to treatment teams in this time period. 186 of the 234 individuals served in that six months obtained a state driver's license or identification card and 183 obtained a birth certificate, the first step in applying for jobs or any entitlement programs.

The Neighborhood Living Project (NLP)
Pittsburgh, PA

Inception: 1997

Treatment Population: Homeless individuals and families affected by mental illness and who are not amenable to traditional treatment modalities

Website: http://ps.psychiatryonline.org

Mr. Curie presents award to The Neighborhood Living Project

The Neighborhood Living Project (NLP) helps homeless individuals and families achieve community stability and maximize their quality of life by providing a continuum of high quality behavioral health care and support services. The goals are to educate clients about mental health and community resources so they can make informed choices unique to their strengths and needs; to provide and/or link clients to the appropriate level of services supports and housing that will enhance their community tenure and quality of life; to provide clients with opportunities to learn and increase behavioral life skills so they can more effectively manage their lives and prevent future episodes of homelessness; and to provide and maintain a high quality of services by implementing the treatment principles of the Assertive Community Treatment (ACT) and Dialectical Behavior Therapy (DBT).

Outcomes (for FY 2004):

- Average occupancy rate was 126%. Over 60% stayed in housing for more than one (1) year. Of those that left, 57% were transitioned to permanent housing.
- At the time of discharge from NLP housing, 52% of clients were involved with a vocational activity and 86% retained or increased their GMI by securing entitlements or obtaining work.
- Of those that left NLP housing, 67% of clients were engaged in mainstream behavioral health services and 74% reported an increase in their quality of life.